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The Clinical Course of Primary Recurrent Depression in Pharmacologically Treated Female Patients

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The main questions of diagnosis and classification of depressive illness put forward by Sir Aubrey Lewis in the 30's are still under discussion. Despite the many published clinical studies of affective illness, there remain—as recently stressed by Klerman (1971)—problems requiring further description and investigation.

This paper presents the clinical course of pharmacologically treated recurrent affective illness in a group of female patients. It describes (i) symptoms and rhythm of depressive attacks throughout the illness, (ii) quality of remission, (iii) associations between background data, symptoms and clinical course.

Controversies about classification and differences in diagnostic criteria mean that terms such as 'affective illness', 'depressive illness', 'recurrent depression', 'endogenous depression' are ambiguous. They will be used here to characterize primary affective illness with either recurrent depressive or depressive and hypomanic episodes occurring in individuals without other pre-existing mental disorder and showing no symptoms of other psychiatric illness. This operational definition corresponds in general to criteria for manic-depressive illness. Emphasizing the primary and recurrent character of affective disorder, it excludes depressive syndromes secondary to brain lesions, epilepsy, physical diseases, schizophrenia, neuroses, alcoholism, drug abuse. It also excludes reactive depressions as described by Janet, and also dysphoric-depressive situational reactions in abnormal personalities. The theoretical background for such a definition, as well as comparative description of groups of patients with endogenous depression, schizophrenic depression and other secondary depressive syndromes, have been given elsewhere (Jaroszynski *et al.*, 1967; Kolakowska and Welbel, 1965).

Material and Method

All female in-patients diagnosed as endogenous depression (primary affective illness) in the Psychoneurological Institute (Poland) during the period 1960–66 were examined, treated with tricyclic antidepressants and/or phenothiazine, and followed-up until 1967. Convulsive treatment was not given. Seventy patients included in the present study fulfilled the following conditions: (i) a diagnosis of a primary depressive illness (as defined above) established at a clinical conference; (ii) having suffered at least two depressive episodes; (iii) having had at least the two most recent episodes treated with psychotropic drugs alone.

During the index admission a detailed clinical history was obtained from the patient and her relatives. Records of previous treatment were examined to reconstruct retrospectively the course of the illness. A symptom inventory based on the Hamilton Rating Scale was used for clinical assessment. It included 17 items from the original scale and 8 additional items covering depressive ruminations, crying, hypochondriacal delusions and 'neurotic features' (items 17–21 in Table II). All symptoms were rated on a four-point scale. The ratings were repeated on admission, on discharge, two weeks after discharge and at least every six months during the follow-up period.

Follow-up consisted in regular out-patient care (34 subjects) or interviews repeated every six months (26 subjects) carried on until 1967. In the case of 10 patients who were discharged in late 1966 or who lived too far away, follow-up was too brief to be considered. For 30 subjects it lasted 1–3 years and for 30 others 3–6 years. The majority of patients (46) took low maintenance doses of tricyclic antidepressants and/or phenothiazines throughout the greater part of

the follow-up, and none had any other form of treatment during the whole period of observation.

The clinical course of the illness is presented, combining both retrospective and prospective parts of the study. The data were analysed as to the (i) frequency of particular variables in the whole group (factors from the patient's background, symptoms, characteristics of the clinical course); (ii) associations between variables (χ^2 test with Yates' correction when appropriate); (iii) longitudinal changes in symptoms, duration and frequency of consecutive episodes and in quality of remissions.

The Findings

General characteristics of the group

The 70 patients had in total 396 depressive attacks, 193 involving admissions to hospital. Over 45 per cent of all depressive attacks (169) and 60 per cent of all hospital admission (116) occurred during the period of the study.

Table I shows that at the index admission the majority of patients were aged over 40 (64 per cent), and had histories of at least ten years illness (63 per cent), of three or more depressive episodes (73 per cent) and of at least one previous admission to hospital (67 per cent).

Pre-morbid personality—as reconstructed from all available information—showed no neurotic traits in 45 patients (63 per cent). Among the remaining 25 subjects, 6 were of an asthenic type (timidity, inferiority feelings, tendency to worry, indecision), 12 had pronounced obsessional traits (meticulous, overconscientious, rigid), 7 showed hysterical traits (egocentric, overdependent, suggestible, acting out, emotionally unstable).

The first affective episode occurred in 63 per cent of patients at the age of 20–39 years, in 20 per cent before the age of 20 and in the remaining 17 per cent above 40.

In all 28 patients with the bipolar form of the illness, hypomanic episodes were mild and brief; they usually immediately preceded or followed depression and did not require hospital admission. There was no difference in the age of onset between unipolar and bipolar patients, but a family history of affective or other mental disorder was significantly more common among the latter subgroup (22 of 28 bipolar against 17 of 42 unipolar; $P < 0.01$).

Table I

Characteristics of 70 patients at the index admission and at the end of the observation (in brackets)

A. General	
Age	
20–29	12 (12)
30–39	13 (10)
40–49	17 (16)
50 and over	28 (32)
Marital status	
Married	50
Single	9
Divorced	5
Widowed	6
B. Background	
Mental disorder in the family—39	
Affective	11
Other	15
Affective and other	13
Premorbid personality	
Non-neurotic	45
Neurotic traits	25
C. Illness	
Form	
Unipolar	42
Bipolar	28
Age at onset	
Before 20	14
20–29	26
30–39	18
40–49	7
50 and over	5
Duration (years)	
Less than 5	9 (9)
5–9	17 (16)
10–19	18 (17)
20 and over	26 (28)
Number of episodes	
1	3 (—)
2	16 (9)
3	13 (10)
4	7 (8)
5 or more	31 (43)
Number of hospital admissions	
1	23 (13)
2	24 (21)
3 or more	23 (36)

Precipitating factors

The onset of affective illness was related to external factors in 38 patients (54 per cent). Psychogenic precipitants preceded the first depressive episode in 20 cases. They included bereavement (7), broken engagement (4), broken marriage (3), serious family conflicts (3), and sudden unfavourable change in the life situation (3). In 18 patients the onset of the illness was related to somatic factors, i.e. to a physical illness (6), puerperium (11) and pregnancy (1).

A precipitated onset of the affective illness was significantly more common in the age range 20–39 than in younger or older patients (29 of 44 compared to 6 of 12 younger and 3 of 12 older; $P < 0.05$). It was at this age that 9 of 11 puerperal depressions took place.

There was no difference between patients with precipitated and spontaneous onset of the illness in the frequency of a positive family history, bipolar/unipolar illness or an atypical picture of the first episode.

The proportion of precipitated phases was lower in the later stages of the illness. The decrease was progressive, from 54 per cent in the first episode to 41 per cent, 21 per cent, 20 per cent and 16 per cent respectively in episodes II–V.

Endocrine factors and Clinical course

The first depressive episode occurred in a period of hormonal changes in 22 patients: in 2 subjects at menarche; in 12, as already mentioned, during puerperium (11) or pregnancy (1); in 8 within the first year of the menopause. In 8 other patients with a history of mild depressive episodes the first severe depression and hospital admission occurred at the menopause. Several patients had premenstrual exacerbations during depressive attacks and a severe premenstrual syndrome with depressive colouring during remissions.

The relationship between affective illness and these possibly endocrine factors was particularly strong in 10 patients. In 3 of these depressive episodes appeared in each puerperium; in 3 others the first puerperal depression was followed by a remission lasting over 20 years until the menopause, when depressive episodes occurred repeatedly every year. In 4 subjects episodes were related to the menstrual cycle, as illustrated by a patient whose premenstrual syndrome gradually developed into depressions lasting 2–3 weeks and in whom the clinical course finally lost any relation to the cycle.

Clinical picture and its change throughout the illness

The first depressive episode was observed directly in 3 patients and reconstructed from available sources in the remaining 67. In 40 cases it was mild and the patient was not referred to a psychiatrist; 5 subjects had out-patient psychiatric treatment and 25 (36 per cent) were admitted to a psychiatric hospital. A mild first attack was particularly common among patients below the age of 30 (30 of 40 against 10 of 30 older; $P < 0.01$) and among patients with a positive family history (27 of 39 against 13 of 31 with negative history; $P < 0.025$).

In 45 patients the clinical picture of the first episode was that of a simple depression, with lowered mood as the main symptom, but in 25 (36 per cent) it was more complex. Mild episodes were in 12 subjects coloured or dominated by obsessions (4), reactive features (5) or anxiety (3), while 13 patients with more severe attacks showed transient paranoid delusions (4) or hypochondriasis with anxiety and/or hysterical symptoms (9). Seventeen of these 25 subjects had some atypical features—but not necessarily the same—in all their subsequent episodes, but the remainder had only simple depression in the later attacks. An atypical first episode was significantly more common among patients with unipolar illness (21 of 42 unipolar against 4 of 28 bipolar; $P < 0.01$).

Table II shows the frequency of particular symptoms during the index admission. In all patients the mood was depressed, activity decreased and sleep impaired. Other typical depressive symptoms (items 4–12) appeared in two-thirds of the group. However, a large proportion of patients presented hypochondriasis, irritability, emotional lability and/or 'neurotic' features (items 19–23).

During the index admission, 40 patients showed typical 'endogenous' depression, 13 presented a syndrome of involutional melancholia, with agitation and hypochondriacal or

TABLE II

Frequency of symptoms in 70 patients during index admission

	On admission					After treatment
	Total N	%	'1'	'2'	'3'	
1. Depressed mood	70	100	23	41	6	6
2. Insomnia	70	100	26	38	6	6
3. Decreased activity	70	100	25	30	15	
4. Fatigue	62	88		Not rated		9
5. Anxiety	61	87	27	30	4	7
6. Impaired appetite	60	86	48	11	1	—
7. Depressive ruminations	58	83	34	19	5	5
8. Suicidal ideas/tendencies	56	80	41	10	5	—
9. Crying	53	76	26	27	—	1
10. Guilt feeling	46	66	22	19	5	1
11. Diurnal variations	46	66		Not rated		—
12. Retardation	45	67	30	15	—	—
13. Praecordial symptoms	41	59		Not rated		1
14. Psychomotor agitation	37	53	23	14	—	1
15. Hypochondriasis	33	46	17	14	2	9
16. Gastrointestinal symptoms	33	46	23	10	—	2
17. Irritability	31	44	28	3	—	5
18. Emotional lability	24	34	24	—	—	10
19. Blaming others	23	33	19	4	—	5
20. Histrionic behaviour	21	30	13	1	1	10
21. Mood reactivity	20	29	18	2	—	6
22. Depersonalization	14	20	12	1	1	1
23. Obsessions	13	19	6	5	2	7
24. Persecutory delusions	8	11	4	3	1	—
25. Hypochondriac delusions	5	7	3	1	1	—

paranoid delusions, and in 17 the picture was dominated by 'neurotic' symptoms and/or hypochondriasis. The majority of the latter subgroup (14) had some atypical features throughout the illness, while the majority of 'involutional' patients (10) had simple depression in their other episodes. Only 5 of 30 patients with atypical index depression had bipolar illness.

Of a total of 35 subjects who presented atypical features in one or more episodes, 17 showed them in all consecutive attacks, 8 in the first phase alone and 10 in the later episodes only.

Suicidal attempts were made by 15 patients, most of them with bipolar illness (11 of 28 bipolar against 4 of 42 unipolar; $P < 0{\cdot}01$).

Duration of depressive episodes

A depressive episode was defined as a period of lowered mood and impaired functioning, different from the previous mental state and lasting from the appearance of symptoms until either a recovery or an improvement with a stabilization of the mental state.

Table III classifies depressive episodes I to X according to their duration. The majority of all episodes (59 per cent) were brief, i.e. lasted less than three months, and only 19 per cent exceeded six months. The increased proportion of brief episodes in the later phases is due not to the shortening of consecutive attacks in individual patients but to the inclusion of subjects who have had brief depressions throughout the illness and have suffered a high number of recurrences. Longitudinal analysis shows that the duration of depressions remained stable throughout the illness in 34 subjects (49 per cent), decreased in 7 (10 per cent) and increased in 29 (41 per cent).

Brief episodes I–IV were associated with age under 30 (60 of 93 against 76 of 159 in older; $P < 0{\cdot}02$). Short duration of the first depression was more common among patients with a positive family history (23 of 39 against 10 of 31

with a negative history; ($P < 0{\cdot}05$), but this factor had no relation to the duration of later phases.

Duration of remissions

Remission was defined as an interval between the end of one affective episode and the beginning of the next. Table IV shows that over half of the remissions lasted less than one year (short remissions) and only 1/4 exceeded three years. The proportion of long remissions decreased with each consecutive depression: all but one interval of over ten years occurred during the first or second remission; intervals of over three years were exceptional after the fourth remission, and the proportion of recurrences within one year rose sharply following the third depressive episode.

The duration of the first three remissions was related also to age: intervals of over three years were more common in the fourth decade of life than in younger and older patients (31/55

TABLE III

Duration of depressive episodes

Phase	Number of patients	Duration of depressive episodes							
		Below 3 months		3–6 months		6–12 months		Over 1 year	
		No.	%	No.	%	No.	%	No.	%
I	70	33	47	19	27	13	19	5	7
II	70	40	57	12	17	13	19	5	7
III	61	37	61	15	25	4	6	5	8
IV	51	27	53	16	31	3	6	5	10
V	43	23	53	9	21	8	19	3	7
VI	30	19	63	6	20	2	7	3	10
VII ..	24	17	71	5	21	1	4	1	4
VIII ..	19	13	68	2	11	3	16	1	5
IX	16	15	94	—	—	—	—	1	6
X	12	11	92	1	8	—	—	—	—
Total ..	396	235	59	85	22	47	12	29	7

TABLE IV

Durations of remissions

Remission	Number of patients	Duration of remissions									
		Below 1 year		1–3 years		3–5 years		5–10 years		Over 10 years	
		No.	%	No.	%	No.	%	No.	%	No.	%
I	70	16	23	16	23	8	11	18	26	12	17
II	61	20	33	18	29	4	7	8	13	11	18
III	51	31	61	5	10	6	12	9	18	—	—
IV	47	28	60	12	25	2	4	4	9	1	2
V	36	24	67	5	14	6	16	1	3	—	—
VI	29	20	69	8	28	—	—	1	3	—	—
VII ..	25	23	92	2	8	—	—	—	—	—	—
VIII ..	22	19	87	2	9	1	4	—	—	—	—
IX	15	14	93	1	7	—	—	—	—	—	—
X	11	11	100	—	—	—	—	—	—	—	—
Total ..	367	206	56	69	19	27	7	41	11	24	6

against 30/77 in younger and 15/50 in older; $P < 0{\cdot}025$), and all but one remission of over ten years started before the age of 40.

Recurrences within one year were characteristic of 43 patients and significantly more common among subjects with bipolar illness (24 of 28 bipolar against 19 of 42 unipolar; $P < 0{\cdot}01$). In 16 patients remissions were short throughout the illness and in 27 long initial intervals contracted to less than one year after 2–6 depressives episodes.

Quality of remission

Fourty-four patients (63 per cent) had complete remissions, becoming asymptomatic, with fully restored premorbid functioning. In the remaining 26 subjects (37 per cent) remissions were partial, with some persisting symptoms and impaired social functioning. The most common residual symptoms were decreased activity, hypochondriacal attitude, emotional lability, histrionic behaviour and anxiety, as found at the end of the index admission (Table II). In all but one of these 26 patients initial depressive episodes were followed by a complete recovery and the first partial remission appeared after 2 to 6 depressive attacks. Once a partial remission had occurred in a patient all her subsequent remissions were also partial. In consequence, the overall proportion of incomplete remissions in the group increased after each consecutive attack, reaching 11 per cent after four episodes and 26 per cent after five or more episodes. The increase with age was even more pronounced. All episodes occurring below the age of 30 resulted in complete recovery, and the first partial remissions appeared in 7 subjects in the fourth decade of life, in 8 in the fifth and in 11 above the age of 50. The overall proportion of patients with partial remissions in these age ranges were, respectively, 15 per cent, 29 per cent and 50 per cent.

Hospital admissions

Less than 50 per cent of all depressive episodes resulted in hospital admission (193 of 396), and only 25 patients were admitted to hospital in their first attack. This was significantly less common below the age of 30 (8 of 40 against 17 of 30 older; $P < 0{\cdot}01$).

The majority of admissions I–IV (115 of 175 —66 per cent) lasted less than three months and only 11 per cent (19) exceeded six months. All patients staying in hospital for over six months during the index admission (10) had abrupt and frequent clinical changes, with improvement or mild hypomania lasting 4–10 days and followed by a return of depression.

Fifty-six patients had more than one admission to hospital. Table V shows that the majority of intervals between their 123 re-admissions did not exceed three years and the proportion of longer intervals decreased with further admissions.

All re-admissions in patients aged over 50 occurred within five years from the last discharge, and intervals lasting less than one year were significantly more common at this age (20 of 34 against 28 of 89 below the age of 50; $P < 0{\cdot}01$).

Treatment

In the case of 40 patients administration of psychotropic drugs was the only method of

TABLE V
Intervals between successive admissions

Admission	Number of patients	Intervals between successive admissions							
		Below 1 year		1–3 years		3–5 years		Over 5 years	
		No.	%	No.	%	No.	%	No.	%
I/II ..	56	12	21	12	21	8	14	24	43
II/III ..	38	21	55	8	21	4	10	5	13
III/IV ..	18	7	39	7	38	4	22	—	—
IV/V and further	11	8	73	3	27	—	—	—	—
Total ..	123	48	39	30	24	16	13	29	24

treatment throughout the illness. The remaining had been given ECT or other forms of therapy in their early episodes, before the index admission.

During the index admission, 25 patients received thioridazine (100–400 mg./day) or laevomepromazine (75–200 mg./day), and the remaining had tricyclic antidepressants (imipramine or amitriptyline 100–175 mg./day) combined with small doses of phenothiazines.

During the follow-up period 46 subjects with residual symptoms and/or a history of frequent recurrences had continuous maintenance treatment, and 14 patients discontinued their medication within 2 to 4 months from discharge. The maintenance doses of drugs were low and only exceptionally exceeded 75 mg. of tricyclic antidepressants and/or 75–100 mg. of phenothiazines per day.

A reduction of medication after the improvement had been achieved was followed by the reappearance of symptoms in some instances but had no apparent clinical consequences on other occasions. Relapses were not less frequent among the subjects receiving the maintenance treatment throughout the follow-up period than among those who discontinued their medication. However, this comparison is of little value, since the latter group was small and included mostly patients with relatively long previous remissions.

Discussion

The group of female patients studied corresponds in its main characteristics to descriptions of bipolar and unipolar manic-depressive illness. In particular, symptoms during the index admission, traits of premorbid personality and proportion of patients with positive psychiatric history in the family are in agreement with commonly reported findings (e.g. Kinkelin, 1954; Perris, 1966; Shobe and Brion, 1971). However, some features of symptomatology and clinical course are less typical. The onset of the illness was precipitated by external factors in a large proportion of cases, the first and/or later depressions were atypical in 50 per cent of subjects, over half of all depressive episodes lasted less than three months and recurred within one year, and 37 per cent of patients had partial remissions. Although these characteristics do not correspond to the cliche of manic-depressive illness and could be misleading, similar findings have been reported in the literature.

While the high proportion of 'precipitated' first depressive episodes runs counter to the concept of an illness following an independent course, it is well within the range of 20–80 per cent reported by other authors (e.g. Garmany, 1958; Kinkelin, 1954; Taschew, 1965). The progressive decrease of precipitated phases, as noted also by Astrup (1959), suggests that they are only of marginal aetiological significance.

Atypical depressions in patients with primary affective illness have been described in several publications (e.g. Anchersen, 1962; Deniker 1957). Among our patients with atypical, episodes, only some showed atypical features throughout the illness and these were not always the same in all attacks. Variation of symptoms between successive episodes suggests that atypical features could be accidental and due to various factors. In some patients they were associated with particular age ('involutional' syndrome) or life events ('reactive' traits); in others they seemed to be related to premorbid personality, as described by Lazare and Klerman (1968) in subjects with hysterical traits.

Remissions with residual symptoms and impaired social functioning—although not consistent with the concept of 'lucid intervals'—have been commonly reported (e.g. Carlson *et al.*, 1974; Dorzab *et al.*, 1971; Lundquist, 1945; Paykel and Weissman, 1973). In our group all but one of the patients with partial remissions made a complete recovery from the first depressive episode, and the picture of partial remission differed from that of the depressive phase by the absence of 'endogenous' symptoms in the residual pathology.

The duration of depressive episodes and hospital admissions in our group was much shorter than has been commonly described (Kinkelin, 1954; Norris, 1959; Rennie, 1942) but close to descriptions of patients treated with ECT and antidepressants (Angst, 1961; Carney *et al.*, 1965; Kessel and Holt, 1965). In summary, our patients differed from the cliche of manic-

depressive illness by a relatively common occurrence of brief, mild and/or atypical depressions separated by short and partial remissions. Two main factors which could account for these deviations are the changed field of psychiatric observation and the impact of biological treatment. Before the era of active biological therapy, mild depressive episodes were seldom brought to the attention of psychiatrists, only depressions involving hospital admission were counted as attacks, and consequently intervals between admissions were considered as remissions. The onset of the illness appeared to occur later if mild initial attacks were not included. Treatment with antidepressants has been shown to shorten the duration of depressive episodes and of hospital stay. It is likely that in some instances this treatment may prevent development of more severe and 'endogenous' picture of the attack. Some authors consider the increase in proportion of brief and poor remissions to be a direct and unfavourable effect of ECT and pharmacological treatment (Borel, 1965; Till and Vuckovic, 1970; Wardaszko, 1965; Zislin, 1963). However, in some cases such brief and frequent depressions separated by partial remissions could represent a single continuous episode modified by the treatment. Some patients with short and partial remissions may belong to the category which, when untreated, tended to become chronic and to remain as a 'sediment' in psychiatric hospitals, as described by Hastings (1958) in 28 per cent of his manic depressives. The fact that in our group only 7 per cent of episodes lasted over one year supports this explanation. It is also consistent with the concept of antidepressants as 'covering' rather than curing depression, and with the fact that in some instances an attempt to reduce or to discontinue treatment during an apparently established remission leads to reappearance of symptoms.

According to the longitudinal analysis, in the majority of patients the duration of depressive episodes increased or remained unchanged throughout the illness. The increased proportion of brief episodes in later attacks, noted also by Taschew (1965), was due to the high number of recurrences in subjects with brief depressions throughout the illness rather than to the shortening of the later phases. The length of remissions varied considerably between patients. Some subjects had recurrences within one year from the onset of their illness (23 per cent); in others initial long remissions contracted to less than one year after 2–6 episodes (39 per cent); the third subgroup had long remissions throughout the illness (38 per cent). Once remission became brief and/or partial in a patient, the subsequent remissions were also brief and/or partial.

Positive psychiatric history in the family, polarity of the illness, age at onset and present age were of some prognostic significance for the clinical course. A positive family history was associated with bipolar illness and with a mild, brief first episode not requiring admission to hospital, as found also by Mendlewicz *et. al.* (1972). Early onset (below the age of 30) was associated with the same features of the first depression. No differences in symptomatology were found between patients with early and late onset, which is consistent with some reports (e.g. Cassidy *et al.*, 1957) but not with the large material of the St. Louis group (Baker *et al.*, 1971). Age over 50 years was of unfavourable prognostic significance for the duration and quality of remissions and for the length of intervals between readmissions. This unfavourable change of the clinical course in the sixth decade of life has been stressed by several authors (e.g. Kinkelin, 1954; Perris, 1966; Post, 1968; Rennie, 1942), but there are also reports that older patients treated with ECT and antidepressants have an equally good prognosis as younger subjects, or even a better one (Kiloh *et al.*, 1962; Ottosson, 1962). The number of previous recurrences was also associated with brief and poor remissions.

The bipolar form of the illness was associated with family history of mental disorder and with short remissions, as found also by Bunney (1971), Perris (1966) and Taschew (1965). Suicidal attempts were more common and atypical depressive episodes less common in this group than in unipolar patients.

The studied group was restricted to female subjects, and only a separate investigation could show whether and to what extent the findings apply to male patients. Since in a proportion of our subjects the course of the

affective illness seemed to be related to the menstrual cycle and/or puerperium, one could expect, in particular, a somehow different rhythm of depressive episodes in men.

Summary

Seventy female in-patients with primary recurrent depression were examined. Sixty of them were followed-up for between one and six years. Clinical course of the illness was reconstructed from both retrospective and prospective data. The patients had a total of 396 depressive episodes, 193 of them resulting in hospital admission. Over 45 per cent of all depressive attacks and 60 per cent of all admissions occurred during the period of the study and were treated with psychotropic drugs alone. Twenty-eight subjects with bipolar affective illness had mild hypomanic episodes which did not require hospital admission.

Over half of all depressive episodes lasted less than three months and recurred within one year. Atypical depression, with neurotic, hypochondriacal or involutional picture appeared in 35 patients during one or more episodes.

Recurrences within one year throughout the illness were characteristic for 23 per cent of the group, and in a further 38·5 per cent remissions contracted to less than one year after 2–6 episodes. Duration of the episodes usually either remained unchanged (49 per cent) or increased (41 per cent). All but one subject made a complete recovery from the first depression. Partial remissions became established after 2–6 episodes in 25 patients.

Brief and poor remissions were more common over the age of 50, but the age of onset was of no important prognostic significance. Brief remissions and suicidal attempts were more common among patients with bipolar illness.

The group differed from the classical course of manic-depressive illness by showing a relatively common occurrence of brief, mild and/or atypical depressive episodes separated by brief and partial remissions. The possible relation of these characteristics to the effect of the treatment is discussed.

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